Planned Parenthood of Northern New England

443 Congress St., 3rd Floor
Portland ME 04101
207.687.3289

Planned Parenthood of Northern New England Comments to the MaineCare Redesign Taskforce on Family Planning Opportunities for MaineCare Savings

Commissioner Mayhew, Members of the Taskforce,

At your September 25, 2012 meeting, DHHS consultant Seema Verma outlined several areas in which the MaineCare program can potentially find cost savings while retaining quality. As she said, there are many examples of short, medium, and long term savings, some of which do reach short term savings but do not continue to show long term savings. Taking advantage of the Family Planning benefit expansion allowed in the Affordable Care Act (ACA) is a structural change to MaineCare that will generate modest savings in the medium term and will grow over time to more significant savings. Savings is achieved not only by averting unintended and high risk pregnancies, but also by averting later costs both until and beyond birth. This savings has played out consistently in the 26 states which have implemented the program.

The Centers for Medicaid and Medicare (CMS) has given states the enhanced $9 to $1 match for the mandated family planning benefit (within the overall benefit package) since the program's inception, and this enhanced match applies to program expansions, as well. The expansion began as a waiver program in a handful of states, and the results were so convincing that CMS gave waivers to all states requesting them. When designing changes to Medicaid in the ACA, the administration decided to make the process easier than the waiver, and made it possible for states to choose to add this program to their current state plans with a simple *state plan amendment* (SPA). In addition to the 26 states which are participating in this program, other states (including Vermont and New Hampshire) have had their SPAs approved and are now in the process of implementation.

MaineCare currently covers pregnant women up to 200% of the Federal poverty level; in order to attain the highest possible savings, this level is recommended for the limited family planning benefit. The benefit is limited in that it will cover eligible women (and men) for basic family planning care only: breast, cervical cancer, and sexually transmitted infection screening and treatment; annual exams; appropriate contraception; and very little else. This is not a way to bring more people onto the program for full benefits; it is a very narrow program.

Nor is this a radical or liberal plan; in fact, the entire Southeast US except Florida (which has a limited program) has implemented this program (map p. 3). It is not for family planning health centers only; it applies to all MaineCare providers, including Federally Qualified Health Centers and private providers. The cost for this program is just over $200 / member / year.

Following is a fact sheet on the program, a map of the states which are presently using the program (it does not include those states in the implementation process), then an excerpt from a 2011 Guttmacher Institute study on states taking advantage of this program, with a page specifically on Maine. Obviously if CMS gives the state the requested waiver from the Maintenance of Effort requirement, the numbers would be different. Either way, MaineCare will save substantial money by implementing this program.

Thank you for your time and attention.

Megan D. Hannan
Director of Public Affairs
megan.hannan@ppnne.org
207.210.3409

Community Based Healthcare

According to Federal Medicaid law, Medicaid (MaineCare) members may seek treatment at *any willing provider.* That includes private practice, but most people prefer their care in the community, given by their community health center. This includes Federally Qualified Health Centers (FQHCs) and "look alikes," Community Action Program (CAP) health centers, and family planning health centers. Community-based health centers are low-cost, high quality, health care providers.

Community Based Healthcare Works for Maine –Wellness

- Adults aged 19 – 40 are generally in good health. They need basic annual check-ups, sometimes sick visits, and when they have children, the children are more likely to have regular health care when their parents do.
- MaineCare can take advantage of a family planning program, which gives a $9 to $1 Federal to state match, to decrease unintended pregnancy and costs associated with it.
- This program provides a limited, but necessary, disease screening: cancer, diabetes, sexually transmitted diseases (including HIV / AIDS), mental health, and health risk assessments.

Community Based Healthcare Works for Maine – Unintended Pregnancy

- This program provides safe, effective, and affordable contraception.
- In Maine in 2006, 50%, or 10,000, of all pregnancies were unintended.
- Unintended pregnancies have many consequences: lower educational attainment; loosing employment; lower use of prenatal care; continued substance abuse, including tobacco and alcohol; higher abortion rates; and mistreated, abandoned, or abused children.
- Access to effective, affordable birth control is crucial to address the cycle of generational poverty.

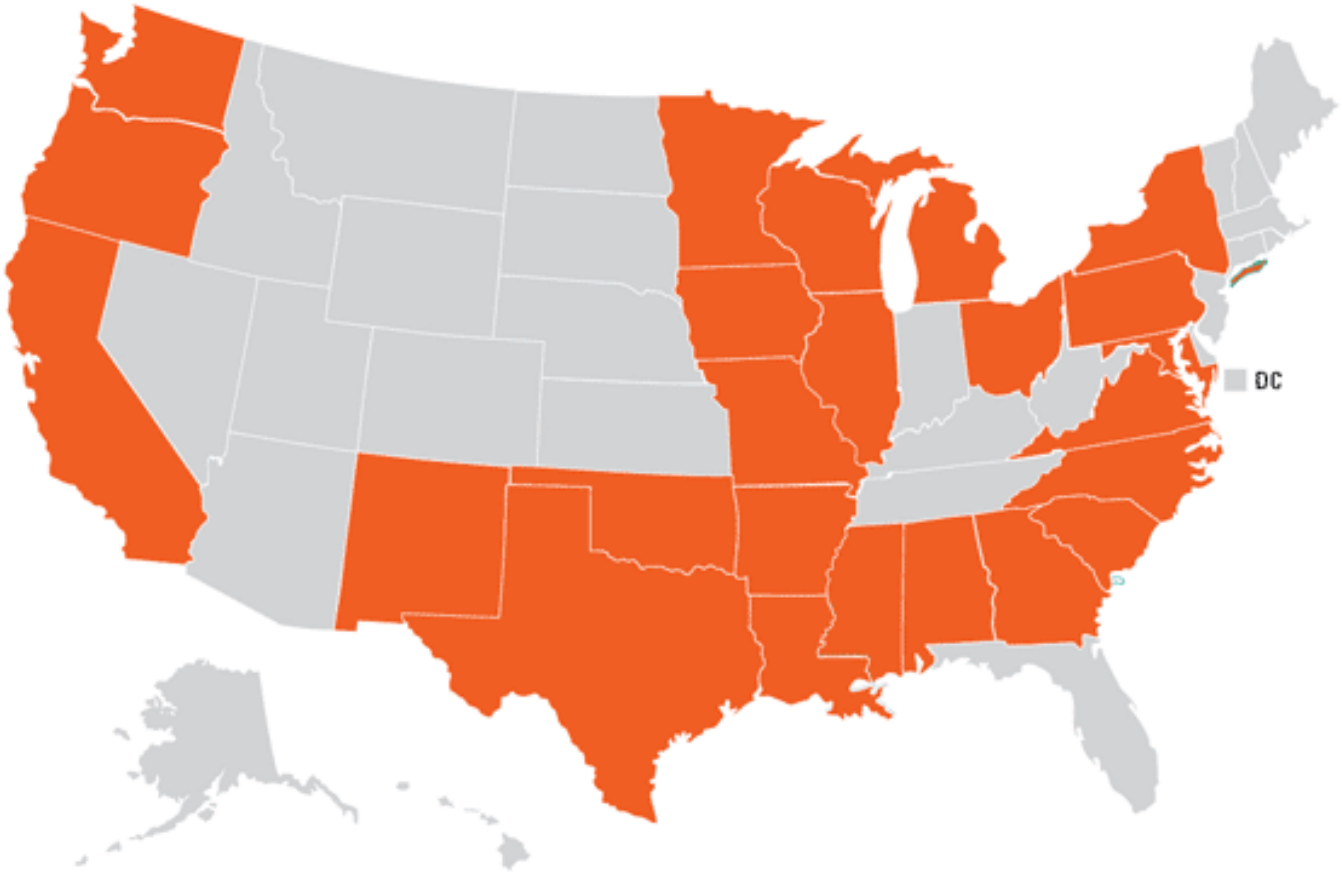
Community Based Healthcare Works for Maine – MaineCare Savings

- Basic screenings allow healthcare professionals to identify early, and often prevent, disease from advancing.
- Total MaineCare spending on births in 2006 was almost $56 million; cost for unintended births was just under $25 million.
- The actual cost of this benefit is about $200 per member per year.
- MaineCare match for these services is $9 - $1.
- Fully implemented, it will save the state almost $2 million (state portion of overall program).
- Since the 1990s, 26 states have implemented this program; each program has resulted in better outcomes and significant savings.

The Family Planning State Plan Amendment is a reliable, appropriate, cost saving measure which increases access to affordable birth control while it decreases unintended pregnancy, abortion, and avoidable high risk births. Affordable family planning is good for Maine women, the economy, and our healthy population.

STATE MEDICAID EXPANSIONS

Twenty-four states have implemented broad-based Medicaid family planning expansions for individuals who are not eligible for full-benefit Medicaid coverage.



Note: As of April 1, 2012. *Source:* Reference 15.

www.guttmacher.org

NOTE: Indiana and Montana have implemented the family planning expansion since this map was created, bringing the total to 26. Rhode Island, Florida, Arizona and Utah have limited programs. Vermont and New Hampshire are in the process of implementing this program.

NOTE: The following report is dated January 2011, therefore the map in it is different from above.

January 2011

GUTTMACHER INSTITUTE

Estimating the Impact of Expanding Medicaid Eligibility For Family Planning Services: 2011 Update

Adam Sonfield, Jennifer J. Frost and Rachel Benson Gold

HIGHLIGHTS

- Over the past 15 years, 22 states have sought and received federal approval to extend Medicaid coverage for family planning services to residents solely on the basis of income under a complicated process known as a "waiver."
- A ground-breaking provision included in the March 2010 health care reform law greatly simplifies the process for a state seeking to expand Medicaid eligibility for family planning and allows for coverage of a larger population than currently included in any existing waiver program.
- This report provides a tool to help gauge the potential impact in each state of taking up this new authority.
- Twenty-eight states do not currently have an income-based family planning expansion. Nineteen states without an expansion could each serve at least 10,000 individuals, avert at least 1,500 unintended pregnancies and save at least $2.3 million in state funds in a single year, by expanding Medicaid eligibility under the new authority. Nine of these 19 states could each serve at least 50,000 individuals, avert at least 7,500 unintended pregnancies and save at least $17.4 million in state funds in a single year.
- Among the 22 states that already have a family planning expansion in place via the older waiver process, 11 could each serve at least 10,000 individuals, avert at least 1,300 unintended pregnancies and save at least $1.7 million in state funds in a single year, in addition to what their expansions achieve today.

Introduction

The purpose of this report is to illustrate the potential of a small but important provision in the 2010 health reform legislation that gives states new authority to expand Medicaid eligibility for family planning services to women and men who are otherwise ineligible for the program. To do so, we have provided new estimates of what states could expect in terms of program participation, the numbers of unintended pregnancies, births and abortions that could be averted, and the resulting cost savings. These estimates are an update of a Guttmacher Institute study published in August 2006, which looked at the potential for similar expansions that many states had initiated under a different, more complicated process known as a "waiver."[1] The new estimates reflect both more recent data when available and specific provisions and requirements of the law. Among other things, the law allows for coverage of a larger population of individuals than currently covered under any existing waiver program, and requires states' expansions to cover adolescents and men—two populations that have been excluded under some waivers.

It should be emphasized up front that these estimates are merely that, estimates. The actual impact of expanded Medicaid family planning efforts would depend substantially on state-level factors, such as outreach efforts and provider capacity. In addition, although our methodology is based wherever possible on states' own reported data and on the experience of existing family planning expansions, policymakers and budget analysts may have access to additional state-specific information that was unavailable to us but that could provide a greater degree of precision. These findings should be viewed, therefore, as demonstrating the potential of expansions, rather than their definite impact. In that light, it is equally important to emphasize that given the options available at various stages of the analysis, we typically chose the analytical approach that would lead to the most conservative estimate.

History of the Expansions

When Medicaid was first established in 1965, the low-income families who in general were covered by the program were single mothers and their children receiving welfare cash assistance. In the 1980s, responding to research that showed both the importance and the cost-effectiveness of prenatal care, Congress broke the link between welfare and Medicaid for low-income pregnant women: It first allowed and later required states to extend eligibility for Medicaid-covered prenatal, delivery and postpartum care to all women with incomes below 133% of the federal poverty level ($18,310 for a family of three in 2010),[2] which was far higher than most states' regular Medicaid eligibility ceilings.[3] At their option, states could expand eligibility for pregnancy-related services to women with incomes up to 185% of poverty or beyond, and most states have done so.[4] As a result of such expansions, Medicaid pays for four in 10 births in the United States each year; in some states, the program funds more than half of all births.[5]

In recent years, about half the states have built on the eligibility expansions for pregnancy-related care by moving to expand eligibility for family planning services under Medicaid as well. These programs include coverage for the package of family planning services and supplies covered for other Medicaid recipients in the state, which generally includes the full range of contraceptive methods, as well as associated examinations and laboratory tests.[6] A long-standing provision of the Medicaid statute allows states to claim federal reimbursement for 90% of the cost of these services and supplies.[7] Although states may include other, closely related care in their package of benefits, such as treatment for STIs diagnosed in the course of a family planning visit, the state must claim federal reimbursement for this care at its regular rate. These rates range from 50% to 76% of the cost, depending on the state, although Congress has provided funding for somewhat enhanced rates through June 2011 as an economic stimulus measure.[8] States are reimbursed by the federal government for the cost of pregnancy-related care at their regular reimbursement rates.

As of November 1, 2010, 22 states had sought and received federal approval to extend Medicaid coverage for family planning services to residents solely on the basis of income, regardless of whether potential participants meet any of the other requirements for Medicaid coverage, such as being a low-income parent.[9] Another three states had applications pending with the Centers for Medicare and Medicaid Services (CMS), the federal agency that

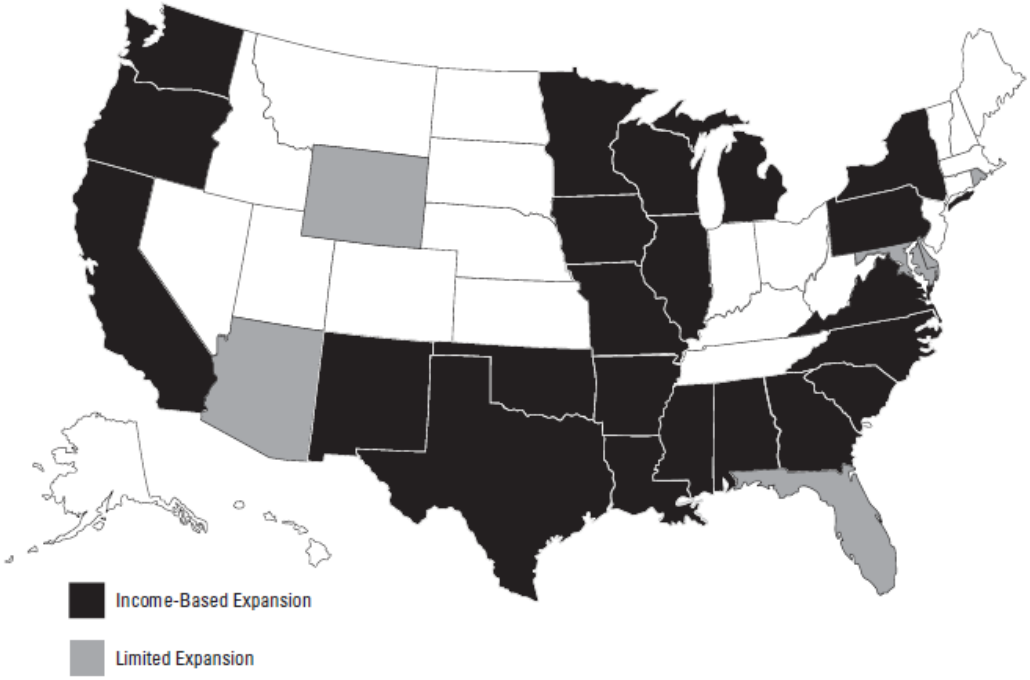
administers the program. This approach directly parallels the earlier expansions for pregnancy-related care. Most of these states extend coverage for family planning to women with incomes below 185% or 200% of poverty. Eight of these states limit their programs to individuals who are at least 19 years of age; three limit coverage to those who are at least 18. Nine include coverage for men in their programs. Six additional states had received federal approval for far more limited, non-income-based programs that extend eligibility for family planning services for some or all individuals who are otherwise leaving Medicaid, such as after the 60-day postpartum period (see map).

Evidence of Impact

According to a growing body of evidence from demonstration waiver evaluations and independent research studies, the broader, income-based programs are having a significant impact. Publicly funded family planning centers, including clinic sites that receive Title X funds and those that do not, in states with broad-based family planning expansions are able to meet more of the need than are those in other states. Centers in the expansion states served 48% of the women in need of publicly funded family planning services in 2006, compared with 36% in other states.* This gap is evidence that the expansions have increased family planning centers' ability to enable women to avoid unintended pregnancies and the abortions that follow.[10] California's Medicaid family planning expansion program, known as Family PACT, helped women in the state avoid 286,700 unintended pregnancies, including 79,200 to teenagers, according to the state's 2007 evaluation.[11] By doing so, the program helped women avoid 128,800 unintended births and 118,200 abortions. In Oregon, unintended pregnancy rates declined from 44 per 1,000 women of reproductive age in 1999, when the state's family planning expansion was implemented, to 38 per 1,000 in 2005.[12]

The expansion programs have helped women avoid unintended pregnancy by enabling them to improve their use of contraceptives. In Washington state, for example, the proportion of clients using a more effective method (defined as hormonal methods, IUDs and sterilization) increased from 53% at enrollment to 71% one year later,

States with Medicaid Family Planning Expansions



Notes: As of November 1, 2010. Income-based expansion refers to states with expansions for women (and sometimes men) whose family incomes do not exceed a specified level, most often at or near 200% of the federal poverty level. Limited expansion refers to states with expansions only for women who have left Medicaid either following a Medicaid-funded delivery or for any reason. *Source:* Reference 9.

according to the state's program evaluation.[13] Similarly, in California, Family PACT clients were both more likely to use any method and to use a more effective method than they were before enrolling in the program.[11]

Short intervals between births—a widely acknowledged risk factor for low-birth-weight deliveries and, therefore, infant mortality and morbidity—have become much less common in some states with family planning expansions. In Arkansas, repeat births within 12 months dropped 84% between 2001 and 2005 for women enrolled in the family planning expansion, and the proportion having a repeat delivery within 48 months fell by 31%.[14] In New Mexico, women accessing family planning services under the expansion were less likely to have a repeat delivery within 24 months than were women who did not access expansion services, 35% compared with 50%.[15] In Rhode Island, the proportion of mothers on Medicaid with birth intervals of less than 18 months fell from 41% in 1993 to 28% in 2003, and the gap between privately insured and publicly insured women narrowed from 11 percentage points to less than one point.[16] And in Texas, 18% of expansion participants had a repeat birth within 24 months, compared with 29% of Medicaid-eligible women who did not participate in the program.[17] Specifically because of the demonstrated ability of these programs to increase spacing between births, the National Governors Association has taken the position that expanding Medicaid eligibility for family planning is an important step states can take to improve birth outcomes.[18]

Some states have also found that their family planning expansion program enables young women to delay a first birth. For example, in Arkansas, the average age at first birth for women enrolled in the Medicaid family planning expansion rose by nearly three and a half years between 1998 and 2005; for all Medicaid enrollees in the state, the average age at first birth increased by just over two years over the same period.[14] In Wisconsin, birthrates for teens in the expansion program were substantially lower than those for all low-income teens from 2003 to 2006. Moreover, births to teens as a proportion of all state Medicaid births declined from 25% in 2000 to 18% in 2006.[19]

In addition, expanding eligibility for family planning under Medicaid permits a woman to establish a relationship with a health care provider prior to pregnancy. This, as recognized by the March of Dimes, increases her likelihood of obtaining the timely prenatal care needed if and when she eventually does become pregnant.[20]

Because the cost of providing Medicaid-covered, pregnancy-related care greatly outstrips the cost of providing contraceptive services, giving women access to the contraceptive services they need and want generates significant state and federal savings. In fact, CMS recently noted that states have been allowed to expand eligibility for family planning under Medicaid precisely because of the cost-effectiveness to the program.[21] For example, according to a federally funded evaluation of state Medicaid family planning expansions completed in 2003, all of the programs studied yielded significant savings to the federal and state governments. States as diverse as Alabama, Arkansas, California, Oregon and South Carolina each saved more than $15 million in a single year by helping women avoid unintended pregnancies that would have resulted in Medicaid-funded births.[22] More recent data are available from some of the evaluations conducted by states. Wisconsin estimates that its program generated net savings of $159 million in 2006.[19] Moreover, data from the Texas Health and Human Services Commission show that by serving 75,800 women in 2008,[17] the state's Medicaid family planning expansion yielded net savings of $42 million.[23]

New State Authority

In acknowledgement of the effectiveness and cost-effectiveness of these programs, a ground-breaking provision included in the omnibus health care reform legislation that was enacted in March 2010 greatly simplifies the process for a state seeking to expand eligibility for family planning under Medicaid.[24] In the past, the only option for a state seeking to expand was through approval of a research and demonstration waiver from CMS, which allows a state to bypass standard Medicaid rules to provide a limited benefit package and to cover individuals who otherwise would not be eligible. Although not required by law or statute, CMS has historically required that waivers be budget neutral to the federal government—that is, they cannot cost the federal government more than it would otherwise have spent in the absence of the waiver. Even though states have been able to meet this threshold, the process of demonstrating budget neutrality was a time-consuming one. Waiver applications are given extensive review within CMS, and are examined by the Office of Management and Budget as well. CMS also requires that waivers have an extensive evaluation component, consistent with their role as demonstration initiatives. On aver-

*Women in need of publicly subsidized contraceptive services include those who are sexually active, of reproductive age (13–44), able to become pregnant and not pregnant, postpartum nor trying to become pregnant, and who either have a family income below 250% of the federal poverty level or are younger than age 20 and are therefore assumed to have a low personal income.

age, it has taken roughly two years for a state to secure approval of a Medicaid family planning waiver.[25]

The provision included in the health care reform legislation gives states a second option: It allows states to expand eligibility for family planning by amending their state Medicaid plans, a far simpler process than that which states needed to endure to secure approval of a waiver. A state must still obtain federal approval for a state plan amendment (SPA), but that is generally a faster and more streamlined process than that for a waiver. Moreover, a SPA is a permanent change to a state's Medicaid program, unlike a waiver, which is initially granted for a five-year period and then renewed in three-year increments.

The legislation permits states to set the eligibility level for family planning up to the highest level for pregnant women in place under either the state's Medicaid or Children's Health Insurance Program (CHIP) state plan. Subsequent guidance issued by CMS specifies that states seeking to avail themselves of this option must include all individuals in the state who are not pregnant and who meet the income eligibility criteria established by the state.[21] As a result, states may not exclude individuals based on age or gender, even if these individuals would not have been eligible for coverage under a waiver previously obtained by the state.[26]

As described by the Energy and Commerce Committee of the House of Representatives, the statutory provision was designed to enable state Medicaid programs to cover family planning services and supplies for any individual who would be eligible for Medicaid or CHIP coverage of pregnancy-related care.[27] To reach this goal of true parity in eligibility, the CMS guidance makes clear that a state may use the same methodology for determining income eligibility under a family planning SPA as it uses for pregnancy-related care.[21] This includes counting each applicant as two people in the household when determining income eligibility, a methodology not previously permitted by CMS under a family planning waiver that will allow coverage for a greater number of individuals. States choosing to use the same methodology for determining eligibility for family planning as they use for pregnancy-related care would need to apply that methodology to both women and men. In addition, in making eligibility determinations, states have the option to consider only the income of the applicant and not the income of other family members.

In addition, several restrictions that had been applied to family planning waivers in the past are not applicable to SPAs. For example, states may utilize an enrollment strategy known as presumptive eligibility, through which an applicant may be granted immediate but temporary eligibility by a qualified health care provider. Although documentation for various factors of eligibility—such as citizenship—is not required for the presumptive determination, applicants must provide that documentation to convert that temporary eligibility into full enrollment. In addition, CMS does not limit coverage under SPAs to individuals who are uninsured, a requirement that had been imposed under waivers in the past. (However, as is the case for Medicaid generally, states are obligated to receive reimbursement from third-party payers.)

A family planning SPA must provide coverage for all family planning services and supplies covered under the state's full-benefit Medicaid program; these services may be reimbursed at the special 90% federal reimbursement rate for family planning. In addition, states must cover at least some—but not necessarily all—family planning–related services, which are defined as "medical diagnosis and treatment services that are…provided in a family planning setting as part of or as follow-up to a family planning visit." Related services may include drugs for treating STIs when diagnosed during a family planning visit, rescreening for STIs based on guidelines from the Centers for Disease Control and Prevention, an annual visit for men, colposcopy services, repeat Pap tests or the human papillomavirus vaccine. States may be reimbursed for these related services at their regular federal reimbursement rate. As under full-benefit Medicaid, states must cover transportation services needed by individuals enrolled under a family planning SPA, a requirement not applicable under a family planning waiver.

All of these options and requirements under a SPA apply equally to every state, whether it be a state looking to expand Medicaid eligibility for family planning services for the first time or one that has an existing family planning waiver but is looking to transition to a SPA. This report provides estimates for what taking up the SPA authority could mean for both types of states.

State Tables

This chapter includes 51 tables, one for every state and the District of Columbia. The information presented is different depending on whether the state currently has a family planning expansion in place.

For states that do not have an existing family planning expansion (or have only a limited expansion, such as for women otherwise losing Medicaid coverage postpartum), the data presented are estimates of the potential impact if a family planning SPA were initiated. The table first shows the state's highest current eligibility level for pregnancy-related care under Medicaid or CHIP. Next, the table presents the findings for both an expansion to Nominal Parity and for an expansion to True Parity. Within each of those scenarios, the table presents the potential impact during the first year of program operation and for a "mature" year of an expansion, reflecting the fact that the first year differs from subsequent years in two key respects: First, expansion participation goes through an initial ramp-up period and second, the savings for most births averted to first-year participants do not accrue until the second year.

For each column, data presented include the number of projected expansion participants, which ranges from 4,200 in the less populous states of North Dakota and Wyoming to 259,300, in the much more populous state of Florida for a mature program under Nominal Parity, and from 5,200 in North Dakota and Vermont to 293,000 in Florida under True Parity. The table then presents numbers of unintended pregnancies, abortions and unintended Medicaid births averted; estimates for unintended pregnancies averted range from 600 in North Dakota and Wyoming to 36,840 in Florida for a mature program under Nominal Parity and from 730 in North Dakota and Vermont to 41,620 in Florida under True Parity. Next, it presents the total Medicaid savings from births averted, expenditures on expansion services and net savings, as well as the state government's share of these costs and savings. (The federal government's share is not presented, but may be calculated by subtracting the state's share from the total.)

Notably, because the savings for most births averted to first-year participants do not accrue until the second year, a new expansion may have an overall net budgetary cost in the first year. Yet, because states pay only 10% of the costs of family planning services but a greater share for maternity care, states themselves—as opposed to the federal government—would in almost all cases see a net budgetary savings even in year one. For a mature program, the state's share of the net savings range from $1.3 million in the District of Columbia to $73.8 million in Florida under Nominal Parity and $1.4 million to $83.3 million in the same states under True Parity.

For those states with an existing family planning expansion, we present estimates of the potential impact of switching to a SPA. The table begins by listing out three key parameters for the states' existing expansions: their current eligibility level and whether they cover men and adolescents. It then lists the state's eligibility level for pregnancy-related care. Then, it presents two columns of findings, one for each scenario (Nominal Parity and True Parity). Because these states have already initiated an expansion, no first-year estimates are included.

The estimates for these states include any additional participation that could be expected from a change in income eligibility, either at the Nominal Parity level, if their waiver is not yet at that level, or at the True Parity level, which is above the current eligibility level for all states with waivers. It also includes new costs and savings (if applicable) from covering adolescents, men and transportation services. Because for many states with existing expansions, the Nominal Parity scenario would entail no increase in female participation—and therefore no Medicaid births averted in our estimates—that scenario may simply represent the additional costs from transportation services and, possibly, from adding male participants. (Although serving men presumably does avert some unintended pregnancies, that is not captured in our estimates.) The True Parity scenario, by contrast, would always entail a substantial expansion in female participation, reducing unintended pregnancy and resulting costs. Net cost-savings for the states range from $206,000 in Mississippi to $36.6 million in California under True Parity.

All estimates are in 2008 dollars, and all are for a one-year period. This report includes only state-level estimates, reflecting the fact that Congress has played its role, and the most pressing decisions now are at the state level: whether individual states will choose to take up the new authority that Congress has granted them. Adolescent and

male participants are included in the findings presented in the 51 state tables; two additional tables, breaking out the data specifically for these subgroups, are included in the appendix (Appendix Tables B and E).

As noted previously, the ultimate impact of an expansion would depend greatly on state-level decisions and factors, including the full package of services covered, the quality of care provided, the capacity of the provider network and the level of investment needed to the state's Medicaid systems. Moreover, state-level policymakers may have access to additional, state-specific data not available to us for these estimates. For these reasons, these findings demonstrate the potential of Medicaid family planning SPAs, rather than a definite statement of their impact. To assist states in estimating the impact of this variation, Appendix Table D includes estimates of events averted, costs and savings for each additional 1,000 adult female program participants.

Maine

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **200%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	2,200	7,400	2,600	8,700
No. of events averted				
Unintended pregnancies	320	1,060	370	1,230
Abortions	110	350	120	410
Medicaid births	40	550	50	640
Total costs and savings				
Savings from Medicaid births averted	$392,000	$5,229,000	$457,000	$6,093,000
Expenditures on expansion services	$461,000	$1,538,000	$538,000	$1,792,000
Net savings (or loss)	–$69,000	$3,691,000	–$81,000	$4,301,000
State costs and savings				
Savings from Medicaid births averted	$144,000	$1,919,000	$168,000	$2,235,000
Expenditures on expansion services	$64,000	$215,000	$75,000	$250,000
Net savings (or loss)	$80,000	$1,704,000	$93,000	$1,985,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

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